

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028689

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3982

DO NOT WRITE
ON THIS STUD

AMENDED

FILED AUG 6 1963

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN INDEPENDENCE	
Length of stay in 1b 2 weeks		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION NORTHEAST OSTEOPATHIC		d. STREET ADDRESS (If outside, give location) 9510 WINNER ROAD	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ABBIE LAMB STROUP		4. DATE OF DEATH Month Day Year JULY 12, 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-24-1885
9. AGE (last birthday) 78		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (City and state or country) UNKNOWN, KANSAS		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME SUBEL LAMB		13b. MOTHER'S MAIDEN NAME EVELINA ALEXANDER	
14. NAME OF HUSBAND OR WIFE LEONARD THOMAS STROUP		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO NO	
16. SOCIAL SECURITY NO.		17. INFORMANT Leonard T. Stroup, 9510 Winner Rd., Indep. Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Hypertension-severity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH 6 days 2-3 years 4-5 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Oct 1951 to July 12, 1963 and last saw her alive on July 11, 1963 Death occurred at 142 m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) R. H. Boyd, Jr. M.D.	
22b. ADDRESS 9529 Truman Independence Mo		22c. DATE SIGNED 7-12-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7-15-63	
23c. NAME OF CEMETERY OR CREMATORY MOUND GROVE CEMETERY		23d. LOCATION (City, town, or county) INDEPENDENCE, MISSOURI	
24. FUNERAL DIRECTOR GEO. C. CARSON & SONS, INDEPENDENCE, MO.		25. DATE RECD. BY LOCAL REG. 7-15-63	
26. REGISTRAR'S SIGNATURE Ruth Long			

DOCUMENT

BY AFFIDAVIT OF R. H. Boyd, Jr., M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. T. Crowell

Licensed Embalmer No. 4904

P. O. Address

H. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.